





Registered Nurse Education Program

Scholarship & Loan Repayment Application



Giving Golden Opportunities by:

Increasing the supply of health professionals practicing in underserved areas

Improving access to healthcare in the underserved rural and urban areas of California

Helping students to pursue a career in the health professions

Awarding health professionals who are dedicated to practicing in underserved communities.

Application Instructions



APPLICANTS MAY APPLY FOR ONLY ONE AWARD USING THIS APPLICATION

The Registered Nurse Education Program offers three types of awards: the **Registered Nurse Loan Repayment**, the **Bachelor of Science Nursing Scholarship**, and the **Associate Degree Nursing Scholarship**. The purpose of these awards is to increase the number of registered nurses (RN) practicing in the medically underserved areas of California.

Applications for the Registered Nurse Education Program are accepted biannually. Any monies awarded under this program are intended to pay or repay tuition, required fees, books, supplies, and educational equipment costs related to the applicant's registered nurse education. All awards are subject to the availability of funding.

Selection Criteria

Selection for Registered Nurse Education awards is based solely on information contained in the application and supporting documentation. Selection for awards is based on the following criteria:

Work Experience—nursing and non-nursing work experience in a medically underserved area (MUA).

Financial Need—actual or potential difficulty in completing education in the absence of an award.

Career Goals—professional goals for the next five to ten years.

Community Service—documented volunteer service and/or activities, particularly in a MUA.

Community Background—family structure and community where you grew up: for example, rural, inner city/urban, suburban, or MUA.

Academic Performance-...

Priority will be given to:

Individuals whose community background and commitment indicates the likelihood of long-term employment in a medically underserved area even after the service obligation has ended; **Students** who will complete their nursing education program within the next two years; and to BSN students who have graduated from an ADN program within the last 5 years.

Awards are made on a competitive basis. Each part of the application must be completed. All supporting documentation must be submitted. Only complete applications will be evaluated. The Foundation will not notify individuals if their application is incomplete.

LOAN REPAYMENT GRANTS

The **Registered Nurse Loan Repayment Program** repays up to **\$8,000** in educational debt that was incurred while attending a baccalaureate degree nursing program. In return for the loan repayment grant, the awardee must agree to practice as a RN in a medically underserved area for a minimum of 2 years.

Awardees may reapply for additional loan repayment grants at the completion of their 2-year service obligation. Awardees may reapply for grants up to a maximum of **\$19,000**.

Loan Repayment Eligibility

Loan repayment grants are available to currently licensed RNs. Awardees must sign a contract with the Office of Statewide Health Planning and Development and agree to the following terms:

Be a U.S. citizen or permanent resident and a California resident. **Complete a 2-year service obligation** to work in a medically underserved area of California as a RN providing direct patient care. While completing the service obligation, **work full-time or work a minimum of 32 hours per 5 day period** or work week Be a currently licensed RN.

Loan Repayment Application

Applications must be postmarked by the deadline. Only complete applications will be reviewed. Each part of the application must be completed. All supporting documentation must be submitted. The Foundation will not notify applicants if their application is received incomplete. Applicants are urged to contact the Foundation prior to the final filing date to verify if their application was received complete. Do not bind or submit applications in a loose-leaf binder.

Submit the following:

1. One (1) official transcript with BSN degree posted. The transcript must be marked official by the school and submitted to the Foundation in a sealed envelope. If the school does not release official transcripts to the student, the transcript may be sent directly from the school to the Foundation. The Foundation will not accept unofficial transcripts, copies or print outs of transcripts, or transcripts in a broken envelope.

Your BSN degree must be posted on the transcript unless you are a student if the final year in a course of study leading to a BSN degree. If you are in the final year of the BSN program, submit the most current transcript(s) that illustrate your BSN education to date.

- *Loan repayment applicants must also submit two (2) photocopies of their application and 2 photocopies of the following supporting documents:
- **2. Personal Statements**. Attach your personal statements to the application. Your statements must be typed. Statements may be short or long. However, please limit all Personal Statements to not more than 6 pages. Restate and number each question along with your answer.
- **3. Two letters of recommendation**. Letters must be current or dated within the last six months of the application deadline. The letters must be on letterhead or include the author's title, name of employer, mailing address, and phone number. It is recommended that at least one letter be from a faculty member.
- **4. Employment Verification Form**. This form must be signed by an official in your personnel department. The Employment Verification Form is enclosed as part of the application. Applicants can also download this form from the Foundation's Web site at www.healthprofessions.ca.gov.
- **5. 2002 Federal tax return with all W-2s**. Do not submit State tax returns. State tax returns will not be accepted in lieu of the Federal tax return.

Application Instructions (cont)



SCHOLARSHIPS

Students may receive up to \$8,000 for the Bachelor of Science Nursing Scholarship and up to \$4,000 for the Associate Degree Nursing Scholarship. Scholarships are funded for one academic year, usually 2 semesters or 3 quarters.

Scholarship Eligibility

Scholarships are available to students who are enrolled or accepted in a baccalaureate or associate degree nursing program. Awardees must sign a contract with the Office of Statewide Health Planning and Development and agree to the following terms:

Be a U.S. citizen or permanent resident and a California resident

Complete a 2-year service obligation to work in a medically underserved area of California as a RN providing direct patient care

Be a full-time or part-time student (no less than 6.0 units) in a California accredited school

Maintain a minimum cumulative GPA of 2.0 each year scholarship funds are sought

ADN scholarship only:

Agree to obtain a BSN within 5 years of obtaining an ADN degree.

Scholarship Application

Applications must be postmarked by the deadline. Only complete applications will be reviewed. Each part of the application must be completed. All supporting documentation must be submitted. The Foundation will not notify applicants if their application is received incomplete. Applicants are urged to contact the Foundation prior to the final filing date to verify if their application was received complete. Do not bind or submit applications in a loose-leaf binder.

Submit the following:

1. One (1) official transcript related to your nursing education. If you are a student in your first year of the nursing program and your transcripts do not reflect your nursing education, submit your most current transcript.

The transcript must be marked official by the school and delivered to the Foundation in a sealed envelope. The Foundation will not accept unofficial transcripts, copies or print outs of transcripts, or transcripts in a broken envelope.

*Students must also submit two (2) photocopies of their application and 2 photocopies of the following supporting documents (items 2 through 5)

- **2. Personal Statements**. Attach your personal statements to the application. Your statements must be typed. Statements may be short or long. However, please limit all Personal Statements to not more than 6 pages. Restate and number each question along with your answer.
- **3. Two letters of recommendation**. Letters of recommendation must be current or dated within the last six months of the application deadline. The letters must be on letterhead or include the author's title, name of employer, mailing address, and phone number. It is recommended that at least one letter be from a faculty member.
- **4. Graduation Date Verification Form**. This form must be signed by the nursing program director or faculty members authorized to sign on the director's behalf. The Graduation Date Verification Form is enclosed as part of the scholarship application. Applicants can also download this form from the Foundation's Web site at www.healthprofessions.ca.gov.
- **5. Student Aid Report (SAR)**. Students must submit the final 2003-2004 SAR. The SAR must indicate the student's expected family contribution (EFC). The FAFSA is available from all college financial aid offices and is also available on the Internet at www.ed.gov/offices/OPE/express.html.

Or

2002 Federal tax return with all W-2s. Applicants who do not apply for financial aid must submit complete copies of their 2002 Federal tax return with all W-2s. Do not submit State tax returns. State tax returns will not be accepted in lieu of the Federal tax return.

INELIGIBILITY FOR REGISTERED NURSE EDUCATION AWARDS

Applicants who owe a conflicting service obligation to practice direct patient care to another entity entered into before filing an application with the Foundation will be ineligible to receive a loan repayment or scholarship.

Awardees who breach their contract with the Office of Statewide Health Planning and Development will not be allowed to reapply of additional awards.

Notification of awards

The Foundation will notify applicants of their application results within eight weeks of the final filing date.

Spring Application POSTMARK DEADLINE: March 26, 2003 Fall Application POSTMARK DEADLINE: September 11, 2003

Submit applications to:
Health Professions Education Foundation
818 K Street, Suite 210
Sacramento, CA 95814
(800) 773-1669 or (916) 324-6500

Application

Reviewed By:

Please refer to the application instructions before you begin.

Registered Nurse Loan Repayment Grant: \$8,000 to \$19,000 Bachelor of Science, Nursing Scholarship: \$8,000 Associate Degree Nursing Scholarship: \$4,000



List any languages you can speak, read, and write in addition PARI A – PERSONAL INFORMATION Check all that apply. to English: (Please type or print your answers in the space provided) 1 _____ Speak Read Write Applicants may apply for only one award using this application. Please indicate which award you are applying for: 2 _____ Speak Read Write ☐ Registered Nurse ☐ Bachelor of Science ☐ Associate Degree Loan Repayment Nursing Scholarship Nursing Scholarship Are you a citizen or permanent resident of the U.S.? \subseteq Yes \subseteq No Please enter the loan repayment or scholarship amount you are Are vou a California resident? \square Yes \square No requesting: \$_____ Do you owe an existing service obligation to another entity? PART **B** – **WORK EXPERIENCE** Yes NO Please list all paid and/or unpaid work experience you may have If yes, please explain. had. List most recent first. Attach additional sheets as needed. Employer's Name Address ______ State _____ Zip _____ Are you a previous awardee of the Foundation? \square Yes \square NO City ____ County ____ If yes, please enter the contract#: __ Your Supervisor's Name: _____ Office Phone: ____ Mailing Address _____ Your Position/title: _____ _____ Monthly Salary: ____ ______ State _____ Zip ____ Paid worker **OR** None paid Full-time **OR** Part-time County ____ Permanent Address Employment Start Date ____/___ Employment End Date ____/___ ______ State _____ Zip _____ Average hours worked (please choose only one): ____/day ____/week ____/month County ____ Brief description of your job duties: Home Phone Work Phone Social Security #: _____ - ____ - ____ CA Drivers License # ____ **Date of birth:** / / Age: Gender: ☐ Male ☐ Female Marital Status: ☐ Unmarried ☐ Married Employer's Name Number of dependents other than self and spouse: _____ _____ State _____ Zip ___ Are you currently employed as a licensed health professional? Yes No Your Supervisor's Name: _____ Office Phone: _____ If yes, provide license # _____ Expiration date ____/___ Your Position/title: _____ Monthly Salary: ____ Are you the first in your family to attend college? \square Yes \square No Paid worker **OR** None paid Full-time **OR** Part-time Which best describes your ethnic background: Employment Start Date ____/___ Employment End Date ____/___ Asian American African American Caucasian Average hours worked (please choose only one): /day /week /month Hispanic/Latino Native American Pacific Islander Other (Please specify) Brief description of your job duties: If Native American, please specify tribal affiliation: FOR OFFICIAL USE ONLY. Omitted: A/Pgs GDV EVF SAR TAX LoR Oth: Recd: Compl / Inc: Applnguiry: (- -) (-**HPEF Contact:** MUA: Yes / No CT# Input by:

Comments:

Application

Please refer to the application instructions before you begin.

Registered Nurse Loan Repayment Grant: \$8,000 to \$19,000 Bachelor of Science, Nursing Scholarship: \$8,000 Associate Degree Nursing Scholarship: \$4,000



PART C - COMMUNITY BACKGROUND

or each age category below list the city county and state you grow up in Chack all

Age Category	Rural	Inner City/Urban	Suburban	Poor	Middle-class
Birth-10 years					
City:		County:			State:
Age Category	Rural	Inner City/Urban	Suburban	Poor	Middle-class
10-20 years					
City:		County:			State:
Age Category	Rural	Inner City/Urban	Suburban	Poor	Middle-class
20-30 years					
City:			0.1.1		State:
Age Category	Rural	Inner City/Urban	Suburban	Poor	Middle-class
30-40 years					
City: Age Category	Rural	County: Inner City/Urban	Suburban	Poor	State: Middle-class
40+ years					
City:		County:			State:
,		,			
Organization Other source Where did you re (Check only one. Financial Aid	or Affiliate (please seceive the dease)	tion (please specify) ion (please specify) pecify) Registered Nurse E Program Director Other Web site	ducation Pro	gram appl	lication form?
☐ Friend/Acqu	aintance				
Other please	e specify _				
Attach your petyped. Restate *Loan repaymen	rsonal sta and num t applican	L STATEMEN Itements to the apper each question ts must answer que p applicants must a	plication. Yo along with y stions 1-5	your ansv	
1. What kind of v	vork do yo	u think you'll be doir	ng in five year	s?	
2. What is your v	vision of yo	u professional futur	e in ten years	?	
the past two year	ırs (Please	service, volunteer a attach any letters o ich you received ac	f recommend	lation you	
		nily background incl rital status, and num			
		ground is relevant to ckground as an adv			
Scholarship app			odiataly after	- المسالة مسم	-0

6. What kind of work would you like to do immediately after graduation?

PART **F** – **APPLICATION CERTIFICATION**

I certify that all information in this application is true and accurate to

the best of my knowledge. I authorize the Health Professions Education Foundation to verify any information submitted as part of this application. I understand that falsification of information contained in this application will disqualify my application and that the Board of Registered Nursing will be notified.

I also understand that if falsification is discovered after I have been awarded, I will be required to repay all funds awarded, plus interest and administrative fees.

I also understand that my personal statements and pictures become the rights of the Health Professions Education Foundation and may be used, including but not limited to, advertising/marketing, program reports, newsletters, and other publications.

Printed name (last name, first name, middle initial)

Applicant's Signature	 Date

SUBMIT APPLICATIONS TO:

Health Professions Education Foundation **Registered Nursing Education Program** 818 K Street, Suite 210 Sacramento, CA 95814

Postmark DEADLINE March 26, 2003 Postmark DEADLINE September 11, 2003

APPLICATION CHECKLIST (Loan Repayment Application) 1. One (1) official transcript with BSN degree posted.
2. Personal Statements.
☐ 3. Two letters of recommendation.
4. Employment Verification Form.
☐ 5. 2002 Federal tax return with all W-2s.
6. Two copies of the original application and attachments

items 2-5. Do not make photocopies of transcr
APPLICATION CHECKLIST (Scholarships)
☐ 1. One (1) official transcript related to your nursing education.
2. Personal Statements.
\square 3. Two letters of recommendation.
\square 4. Graduation Date Verification Form.
☐ 5. Student Aid Report (SAR).

 \square 6. Two copies of the original application and attachments, items 2-5. Do not make photocopies of transcripts.

Graduation Date Verification Form



*Must be completed by the nursing program director or the director's designee.

The student named below is applying for a scholarship from the Health Professions Education Foundation. This form is required for the application to be considered. Please return this form to the Foundation with original signature.

Applicant's Name:			
School of Nursing:			
Address:			
Year Entered:	Expe Month/Year	ected Graduation Date	e: Month/Year
Please comment or	n the student's perfor	mance and potential	for academic success.
Name (Please Print	t)	Title	
Signature		Dat	te
Phone Number ()		
☐ I certify t	hat I am the Program hat I am authorized t the Nursing Program	o sign this document	on

Employment Verification Form



(For Loan Repayment Applicants Only)

ATTENTION! This blank form may be duplicated, however, to be acceptable, the completed form must bear an original ink signature. Photocopies and faxed copies of the completed form are not acceptable.

EMPLOYMENT VERIFICATION FORM (TO BE COMPLETED BY AN OFFICIAL IN THE PERSONNEL OR HUMAN RESOURCES DEPARTMENT)

Employee's Name:				
		Monthly Salary:		
Employer:		Employee's Supervisor: Telephone Number:		
			Zip Code	
County				
Additional Comments:				
This form was comple	eted by:			
Name:		Telephone Number		
		•		
Signature:				

Health Professions Education Program

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